

Manual Title	Chapter	Page
Transportation Manual	II	
Chapter Subject	Page Revision Date	
Provider Participation Requirements	10-1-94	

CHAPTER II

PROVIDER PARTICIPATION REQUIREMENTS

Manual Title	Chapter	Page
Transportation Manual	II	
Chapter Subject	Page Revision Date	
Provider Participation Requirements	10-1-94	

CHAPTER II

TABLE OF CONTENTS

	<u>Page</u>
Provider Enrollment	1
Requests for Participation	1
Exhibit II.1 - Transportation Provider Participation Agreement, DMAS-102	2
Exhibit II.2A - Registered Driver Participation Agreement Form	3
Exhibit II.2B - Registered Driver Participation Agreement Form (Continued)	4
Participation Requirements	4
Participation Conditions	7
Transportation Service Providers	7
Requirements of Section 504 of the Rehabilitation Act	7
Termination of Provider Participation	8
Reconsideration of Adverse Actions	8

Manual Title	Chapter	Page
Transportation Manual	II	1
Chapter Subject	Page Revision Date	
Provider Participation Requirements	3-9-2001	

CHAPTER II PROVIDER PARTICIPATION REQUIREMENTS

PROVIDER ENROLLMENT

A provider of services must be enrolled in the Medicaid Program prior to billing for any services provided to Medicaid recipients. There are a Transportation Provider Participation Agreement and a Registered Driver Participation Agreement. Exhibits II.1 and II.2a and II.2b contain samples of these agreements.

Upon receipt of the above information, a provider number is assigned to each approved provider. This number must be used on all claims and correspondence submitted to Medicaid.

This manual contains instructions for billing and specific details concerning the Medicaid Program. Providers must comply with all sections of this manual to maintain continuous participation in the Medicaid Program.

REQUESTS FOR PARTICIPATION

In order to become a Medicaid provider of services, the provider must request a participation agreement by writing or telephoning:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-5105 or 1-888-829-5373 (in state toll-free), fax – 804-270-7027

PARTICIPATION REQUIREMENTS

Providers approved for participation in the Medical Assistance Program must perform the following activities as well as any other specified by DMAS:

- Immediately notify the Department of Medical Assistance Services, in writing, of any change in the information which the provider previously submitted to the Department.
- Assure the recipient's freedom to reject medical care and treatment.
- Provide services and supplies to recipients in full compliance with Title VI of the Civil Rights Act of 1964 which prohibits discrimination on the grounds of race, color, creed, or national origin.

Manual Title	Chapter	Page
Transportation Manual	II	2
Chapter Subject	Page Revision Date	
Provider Participation Requirements	10-1-94	

EXHIBIT II.1

TRANSPORTATION PROVIDER PARTICIPATION AGREEMENT, DMAS-102

Medicaid Provider Number _____													
Commonwealth of Virginia Department of Medical Assistance Services Medical Assistance Program Transportation Provider Participation Agreement													
This is to certify that SAMPLE _____ <small>Name of Provider</small>													
of _____	_____												
<small>Street Address</small>	<small>City & State</small> <small>Zip Code</small>												
on this _____ day of _____, 19____ agrees to participate in the Virginia Medical Assistance Program (VMAP).													
Provider payments and information <i>if different from above</i> should be sent to _____													
<small>Name</small>													
of _____	_____												
<small>Street Address</small>	<small>City & State</small> <small>Zip Code</small>												
<ol style="list-style-type: none"> 1. The provider is authorized to provide transportation under the laws of the state in which he is licensed and is not as a matter of state or federal law disqualified from participating in the Program. 2. Services will be provided without regard to race, color, religion, or national origin. No handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in (Section 504 of the Rehabilitation Act of 1973 29 USC.794) VMAP. 3. The provider agrees to keep such records as VMAP determines necessary. The provider will furnish VMAP on request information regarding payments claimed for providing services under the State Plan. Access to records and facilities by authorized VMAP representatives and the Attorney General of Virginia or his authorized representatives, and federal personnel will be permitted upon reasonable request. 4. The provider agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests for payment will comply in all respects with the policies of VMAP for the submission of claims. 5. Payment made by VMAP constitutes full payment except for patient pay amounts determined by VMAP, and the provider agrees not to submit additional charges to the recipient for services covered under VMAP. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a medical assistance recipient for any service provided under medical assistance is expressly prohibited. 6. The provider agrees to pursue all other available third party payment sources prior to submitting a claim to VMAP. 7. Payment by VMAP at its established rates for the services involved shall constitute full payment for the services rendered. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider will reimburse VMAP upon demand. 8. The provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended. 9. This agreement may be terminated at will on thirty days' written notice by either party and may be terminated at will by VMAP upon loss of license. 10. All disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act. 11. This agreement shall commence on _____ and terminate on _____ <small>(To Be Completed By DMAS)</small> 													
For Provider of Services by:													
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2" style="text-align: center;">For Department of Medical Assistance Services use only</td> </tr> <tr> <td colspan="2" style="height: 40px;"></td> </tr> <tr> <td>by: _____</td> <td>_____</td> </tr> <tr> <td style="text-align: center;"><small>Director, Division of Client Services</small></td> <td style="text-align: center;"><small>Date</small></td> </tr> </table>		For Department of Medical Assistance Services use only				by: _____	_____	<small>Director, Division of Client Services</small>	<small>Date</small>				
For Department of Medical Assistance Services use only													
by: _____	_____												
<small>Director, Division of Client Services</small>	<small>Date</small>												
<table style="width: 100%;"> <tr> <td>Signature of Provider _____</td> <td>Date _____</td> </tr> <tr> <td colspan="2">Type of Transportation _____</td> </tr> <tr> <td>City or _____</td> <td>County of _____</td> </tr> <tr> <td colspan="2">IRS Identification Number _____</td> </tr> <tr> <td colspan="2">Telephone Number _____</td> </tr> <tr> <td>Medicare Carrier _____</td> <td>Vendor Number _____</td> </tr> </table>		Signature of Provider _____	Date _____	Type of Transportation _____		City or _____	County of _____	IRS Identification Number _____		Telephone Number _____		Medicare Carrier _____	Vendor Number _____
Signature of Provider _____	Date _____												
Type of Transportation _____													
City or _____	County of _____												
IRS Identification Number _____													
Telephone Number _____													
Medicare Carrier _____	Vendor Number _____												
Mail two completed original agreements to: <div style="float: right; text-align: right;"> Provider Enrollment/Certification Unit Department of Medical Assistance Services 600 East Broad Street, Suite 1300 Richmond, Virginia 23219 </div>													
DMAS-102 R7/94													

Manual Title	Chapter	Page
Transportation Manual	II	3
Chapter Subject	Page Revision Date	
Provider Participation Requirements	10-1-94	

EXHIBIT II.2A

REGISTERED DRIVER PARTICIPATION AGREEMENT

Medicaid Provider Number _____

Commonwealth of Virginia
Department of Medical Assistance Services
Virginia Medical Assistance Program
Registered Driver Participation Agreement

This is to certify that **SAMPLE** _____
Name of Provider

of _____

Street Address _____ City and State _____ ZIP CODE _____

on this _____ day of _____, 19 _____, agrees to participate in the Virginia Medical Assistance Program (VMAP).

Provider payments and information should be sent to *if different from above* to _____

of _____

Street Address _____ City and State _____ ZIP CODE _____

- The Provider holds a valid driver's license from the state of his/her residence and his/her vehicle is licensed and inspected.
- The Provider may refuse to transport certain Medicaid recipients as long as such refusal is not based upon race, color, religion, national origin or handicap.
- The Provider agrees to submit accurate claims to VMAP. The Provider agrees to identify to VMAP those Medicaid recipients he will transport, transport only to medical care covered by VMAP and obtain necessary pre-authorization as maybe required by VMAP.
- Payment made by VMAP is full payment and no additional charge can be made to the Medicaid recipient.
- The Provider agrees to follow all applicable state and federal laws and VMAP policies and procedures as they are now and as they may be changed. If the provider is audited by VMAP and payments previously made are found to be incorrect, the provider will pay back VMAP the amount in error.
- The Provider agrees to notify VMAP if his/her license is suspended, revoked, or expires.
- This agreement can terminate with thirty day's written notice by either VMAP or the provider. Thirty days' notice by VMAP is not needed if the provider is no longer legally able to transport Medicaid passengers.
- Disagreements about payments and/or ending this agreement with VMAP will be handled through administrative proceedings held at VMAP offices in Richmond, Virginia. Those proceedings and judicial review will follow the guidelines in the Virginia Administrative Process Act.
- I am currently authorized to operate a motor vehicle in the state of _____

My driver's license number is _____.

My insurance is with _____ I assume liability under this policy.
(Company Name)

For VMAP Use Only

By: _____ Date _____
Director, Division on Client Services

Begin Date: _____

End Date: _____

Signature _____

(Area Code) _____ Telephone Number _____

_____ Social Security Number _____

_____ Date _____

Mail two completed copies to: Provider Enrollment/Certification Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

R7/94

Manual Title	Chapter	Page
Transportation Manual	II	4
Chapter Subject	Page Revision Date	
Provider Participation Requirements	10-1-94	

EXHIBIT II.2B

REGISTERED DRIVER PARTICIPATION AGREEMENT (CONTINUED)

**Department of Medical Assistance Services
Registered Driver Program**

List each Medicaid recipient that you will be providing transportation for.

<u>Recipient Being Transported</u>	<u>Medicaid Identification Number</u>
SAMPLE	
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Registered Driver Name: _____
(Please Print)

Signature Date

PLEASE KEEP THIS FORM ATTACHED TO YOUR PARTICIPATION AGREEMENT. THANK YOU.

Manual Title	Chapter	Page
Transportation Manual	II	5
Chapter Subject	Page Revision Date	
Provider Participation Requirements	10-1-94	

- Provide services and supplies to recipients in full compliance with the requirements of the Rehabilitation Act of 1973 requiring that all necessary accommodations are made to meet the needs of persons with semi-ambulatory disabilities, sight and hearing disabilities, and disabilities of coordination (refer to section regarding the Rehabilitation Act).
- Provide services and supplies to recipients in the same quality and mode of delivery as provided to the general public.
- Charge the Department for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public.
- Accept as payment in full the amount established by the Department to be reasonable cost or maximum allowable charge. 42 CFR, Section 447.15 provides that a State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency. The provider should not attempt to collect from the recipient or the recipient's responsible relative(s) any amount that exceeds the usual Medicaid allowance for the service rendered. For example: If a third party payer reimburses \$5.00 out of an \$8.00 charge, and Medicaid's allowance is \$5.00, the provider may not attempt to collect the \$3.00 difference from Medicaid, the recipient, a spouse, or a responsible relative.
- Accept assignment of Medicare benefits for eligible Medicaid recipients.
- Use Program-designated billing forms for submission of charges.
- Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the transportation provided.

Such records must be retained for a period of not less than five years from the date of service or as provided by applicable state laws, whichever period is longer. If an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved. (Refer to section regarding documentation of records.)

- Furnish to authorized State and federal personnel, in the form and manner requested, access to records and facilities.
- Disclose, as requested by the Program, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to recipients of medical assistance.
- Hold confidential and use for authorized department purposes only all medical assistance information regarding recipients. A provider shall disclose

Manual Title	Chapter	Page
Transportation Manual	II	6
Chapter Subject	Page Revision Date	
Provider Participation Requirements	10-1-94	

information in his possession only when the information is used in conjunction

Manual Title	Chapter	Page
Transportation Manual	II	7
Chapter Subject	Page Revision Date	
Provider Participation Requirements	10-1-94	

with a claim for health benefits or the data is necessary for the functioning of the State Agency. The State Agency shall not disclose medical information to the public.

PARTICIPATION CONDITIONS

All providers enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their individual provider agreements. The paragraphs which follow outline special participation conditions which must be agreed to by certain types of providers.

Transportation Service Providers

Ambulance operators who are certified by the Emergency Medical Service of the State Department of Health become enrolled as participating providers by executing an agreement with the Department of Medical Assistance Services. Payment of Medicaid funds or transportation is limited to commercial vendors or operators who are licensed by the State, such as public taxi cabs, buses, ambulance operators, etc.

The Medicaid Program may enter into contracts with friends of recipients, non-profit private agencies, public agencies, and public carriers to provide transportation to Medicaid recipients. All carriers must sign an agreement with Medicaid. Other applicable requirements are as follows:

- A copy of the Bureau of Emergency Medical Services Certification is required for an ambulance and/or wheelchair van.
- A copy of the State Corporation Commission (SCC) Permit is required for a taxi. (An SCC license is not required for public agencies such as the Department of Social Services.)

Upon receipt of the required documents, the provider will be enrolled and assigned a Virginia Medicaid provider identification number to be used on all billing invoices.

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 of the Rehabilitation Act of 1973 provides that no handicapped individual shall, solely by reason of the handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a condition of participation, each Medicaid provider has the responsibility for making provision for handicapped individuals in his or her program activities.

As an agent of the federal government in the distribution of funds, DMAS is responsible for monitoring the compliance of individual providers. By signing the check, the provider indicates compliance with Section 504 of the Rehabilitation Act.

Manual Title	Chapter	Page
Transportation Manual	II	8
Chapter Subject	Page Revision Date	
Provider Participation Requirements	10-1-94	

In the event a discrimination complaint is lodged, DMAS is required to provide the Office of Civil Rights (OCR) with any evidence regarding compliance with these requirements.

TERMINATION OF PROVIDER PARTICIPATION

The participation agreement will be time-limited with periodic renewals required. DMAS will request a renewal of the Participation Agreement prior to its expiration.

A participating provider may terminate his participation in Medicaid at any time. Written notification of voluntary termination must be made to the Director, Department of Medical Assistance Services, 30 days prior to the effective date.

DMAS may terminate a provider from participation upon written notification 30 days prior to the effective date. Such action precludes further payment by DMAS for services provided recipients subsequent to the date specified in the termination notice.

The Code of Virginia, Chapter 10, Department of Medical Assistance Services, Section 32.1-325(c), mandates that "Any such (Medicaid) agreement or contract shall terminate upon conviction of the provider of a felony."

A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 days, notify the Program of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of State law.

RECONSIDERATION OF ADVERSE ACTIONS

The following procedures will be available to all providers when DMAS takes adverse action. Adverse action for purposes of this section includes termination or suspension of the provider agreement and denial of payment for services rendered based on utilization review decisions.

The reconsideration process will consist of three phases: a written response and reconsideration to the preliminary findings, the informal conference, and the formal evidentiary hearing. The provider will have 30 days to submit information for written reconsideration and will have 15 days notice to request the informal conference and/or the formal evidentiary hearing.

An appeal of adverse actions concerning provider reimbursement shall be heard in accordance with the Administrative Process Act (Section 9-6.14:1 et seq.) and the State Plan for Medical Assistance provided for in Section 32.1-325 of the Code of Virginia. Court review of final agency determination concerning provider reimbursement shall be made in accordance with the Administrative Process Act.

Any legal representative of a provider must be duly licensed to practice in the Commonwealth of Virginia.